## General Medical Information — Form C

**This form must be filled out by a physician, nurse practitioner or physician's assistant and signed by same. (Please type or print clearly.)**

Dear Doctor: Your patient is planning on participating (provided you agree) in various athletic events and/or games that may be strenuous and/or dangerous depending on his/her condition. We ask you to take this into consideration when reviewing the participant's history and exam.

**Patient Name** (Please print) _____ _____ _____
Last First MI

**Primary VA Medical Center:** _____

**Weight:** _____ **Blood Pressure:** _____ **Tetanus Toxoid Date:** _____ (current within 10 years)

**PPD Date:** _____ **Result:** _____ (within 12 months or, if positive, a current chest x-ray report)

**Primary Diagnosis:** _____

**Past and Present Medical History (Diabetes, heart disease, hypertension, etc.):** _____

_____

_____

_____

**Known Allergies:** _____

_____

**Medications patient is taking** (List each or send current Action Profile): _____

_____

**Can patient control his or her own medications?** ❑ Yes ❑ No

**Is the patient visually impaired/legally blind?** ❑ Yes ❑ No (Veteran participants who meet the definition of Legal Blindness (i.e., corrected vision of 20/200 or less) will be allowed to enter the Visually Impaired events).

**Does the patient have any communication problems?** ❑ Yes ❑ No

**Does the patient need assistance with daily care?** ❑ Yes ❑ No If yes, with what? _____

_____

**PLEASE INCLUDE A COPY OF CURRENT EKG**

**Please take time to review the events that the patient is interested in competing in, particularly if he/she will be competing in more strenuous events such as Bicycling, Swimming or Pentathlon, prior to providing clearance.**

**PHYSICIAN CLEARANCE-** *In my opinion, the above individual:*

❑ **Is** cleared to compete ❑ **Is not** cleared to compete If not cleared, reason why. _____

_____

**Name of Examiner (print):** _____

**Signature of Examining Physician:** _____

**Address:** _____ _____ _____ _____
Street City State Zip Code

**Telephone Number:** _____ **Date:** _____